MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

11675

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 151 Pri Geo. St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ____ County ____
City or town ____ Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Gust Alvanos

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thino Alvanos
alive
6(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 25th 1881

8. AGE: Years 58 | Months 7 | Days 25 | If less than one day ____ hrs. ____ min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual occupation: Merchant (Tavern)

11. Industry or business

FATHER
12. Name: John Alvanos
13. Birthplace: Greece

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Thino Alvanos.
Address: 151 Pri Geo. St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21-1939 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. 12 19 1939 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-18 1939, at 10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to Dec 1939, and that I last saw him alive on Dec 18 1939.

Immediate cause of death: Acute Myocarditis + Myocardial Insufficiency — DURATION: 12-16-39
Due to: Chr Bronchitis
Due to: Arteriosclerosis
Other conditions: Bronchial Asthma
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: George C Bard M. D. or other
Address: Annapolis Date signed: 12-19-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11676

1. PLACE OF DEATH (93-c)

County Anne Arundel Registration Dist. No. 22

Village or City Jessup, Maryland. No. House of Correction St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME John Balas If U. S. Veteran, specify WAR

(a) Residence: No. 1628 Thames St. Balto, Md. Ward. Social Security No. 227-10-0045 Poss.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) August 8th, 1893

7. AGE Years	Months	Days	If LESS than 1 day, 9 hrs. or 45 min.
46	4	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Laborer

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Hermot Tikam, Kassa, Czechoslavakia

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Elizabeth Balas

16. BIRTHPLACE (city or town) (State or country) Hermot Tikam, Kassa Czechoslavakia

17. INFORMANT (Address) Record of Md House of Correction

18. BURIAL, CREMATION, OR REMOVAL
Place Cherry Hill Date Jan 6, 1940

19. UNDERTAKER (Address) H. L. Collins Jessup Md.

20. FILED Jan 5, 1940 Clara M. Hasleep Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 21st, (Month) (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19.....; death is said to have occurred on the date stated above, at 9.45 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Hypostatic Pneumonia	12-19-39
History of Chronic Myocarditis	

Other Contributory Causes of importance:

Bronchial Asthma

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Thos. H. Phillips M. D.

(Address) Jessup, Maryland.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE [redacted]Y, WITH UNFADING INK—THIS IS A PERMANENT RE[redacted]ry item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy.	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED FEB 8 1928 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11677

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 43 Murry Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 62 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 43 Murry Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elsie R. Basil

WITHIN CORPORATE LIMITS OF

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Frank N. Basil

6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 29 1877

8. AGE:

Years	Months	Days	If less than one day
62	3		hrs. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Charles H. Russell
13. Birthplace Maryland

MOTHER
14. Maiden name Tempa B. Mitchell
15. Birthplace Annapolis, Md.

16. Informant Frank N. Basil

Address 43 Murry Ave Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31 1939 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19 12 31 1939 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1939, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26th 1939, to Dec 28 1939, and that I last saw her alive on Dec 28 1939.

Immediate cause of death

Angina Pectoris

Due to Arterial Hypertension

Due to Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

Death sudden attack several months

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver Purvis M. D. or other

Address Annapolis Date signed 12/30/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

11678

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: A.A.

County

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 4 Days

Stay in this community (yrs., or mos., or days) ~~4 Days~~ 65 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Rurial Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Winchester, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

WITHIN CORPORATE LIMITS OF

3. (a) FULL NAME August Benzine

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1867

8. AGE:

Years	Months	Days	If less than one day
72		21	hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business None

FATHER 12. Name John H. Benzine

13. Birthplace Germany

MOTHER 14. Maiden name Katherine Shurnig

15. Birthplace Germany

16. Informant August Witt

Address Mayo Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 3 1939 (month) (day) (year)

Cemetery or crematory St. Andrews

Location Mayo. Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 12 - 3 (Date rec'd by registrar) 1939 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1939, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1939, to Dec 1 1939

and that I last saw h[illegible] alive on 12-1-39 1939.

	DURATION
Immediate cause of death Generalized Carcinomatosis	?
Due to Hypertensive Cardio Vascular Renal disease	
Due to Primary carcinoma of stomach. Cyst K. Duration = Unknown	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D.
M. D. or other

Address Eastport, Md. Date signed 12-2-39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11679

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 yrs. 8 mos, 16 das.

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Church Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: JAMES BLAKE

3. (b) Social Security Number: -----

4. Sex: male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 63 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER
12. Name: Charles H. Blake
13. Birthplace: Maryland

MOTHER
14. Maiden name: Adrianna Grinage
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 12-9-9 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Dept.

Address

19. Dec-9 1939 (Date rec'd by registrar) E F J Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6th, 1939, at 7A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21st 1936, to Dec. 6th 1939, and that I last saw him alive on Dec. 6th 1939.

Immediate cause of death: Chronic myocarditis

Due to

Due to

Other conditions: General arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations: -------
Of autopsy: --------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: ------ Injured at work?

23. SIGNATURE: Robert P. Whitewood
M. D. or other

Address: Crownsville, Md. Date signed: 12/6/39

RECEIVED
JAN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11680

(131)

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 2

Village or City Severe No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. it of foreign birth? yrs. mos. ds.

2. FULL NAME Martha Ann Boyer If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard M Boyer

6. DATE OF BIRTH (month, day, and year): Aug 29-1855

7. AGE: Years 85 | Months 3 | Days 29 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): A A Co Md

FATHER

13. NAME: John Garey

14. BIRTHPLACE (city or town) (State or country): France

MOTHER

15. MAIDEN NAME: Caroline Friedhofer

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT (Address): Mrs Esther Heathcote Severe Md

18. BURIAL, CREMATION, OR REMOVAL

Place: Friendship Date: Dec 29, 1939

19. UNDERTAKER (Address): W. Turkeys Son Mooth & Sons

20. FILED: Dec 26, 1939 W. L. Jones D.L. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec 26, 1939 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Oct 16, 1939 to Dec 26, 1939

I last saw her alive on Dec 24, 1939, death is said to have occurred on the date stated above at 12 30 p m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Thrombosis

Date of onset

Other Contributory Causes of Importance:

Cardio Vascular Renal Disease & Essential Hypertension

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Jon R Lipsley M. D.

(Address) Clinton Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. N.

MARGIN RESERVED FOR BINDING

N. B.—WRITE [illegible]LY, WITH UNFADING INK—THIS IS A PERMANENT RE[illegible]D. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11681

Reg. Dist. No. 23

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ferndale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Ferndale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Cranery Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Dandy Bradshaw

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): March 22, 1939

8. AGE:

Years	Months	Days	If less than one day
	8	22	hrs. min.

9. Birthplace: Ferndale, A. A. Co, Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name: Dandy Bradshaw
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: Ferndale, Md

16. Informant: Mary Bradshaw
Address: Ferndale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16-1939 (month) (day) (year)
Cemetery or crematory: Mt Pleasant Baptist Cemetery
Locality: Harwood Co Md

18. Funeral director: Robert E. Williams
Address: 1515 McElderry St

19. Dec. 15 1939 Mabel Allen
(Date rec'd by registrar) Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 1939, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19; and that I last saw him alive on 19; that I viewed the body after death on 19; that I have made a personal examination of the body; that I have made an autopsy; that I have not made an autopsy; that I have not made a personal examination of the body.

Immediate cause of death	DURATION
Bronchio-pneumonia	2 weeks
Due to Acute Bronchitis	1 week
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: no
Of autopsy: no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John M Caffey Deputy Medical examiner
M. D. or other
Address: Annapolis Md Date signed 12/13/39

RECEIVED
JAN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11682

93-C

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 22

Village or City Jessups No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Elijah Brown If U. S. Veteran, specify WAR

(a) Residence: No. West Street, Annapolis, Md. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Black

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) March 15, 1872

7. AGE: Years 67 | Months 8 | Days 20 | If LESS than 1 day 5 hrs. or 50 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Jones Station (State or country) Maryland

FATHER

13. NAME Anse Brown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT none (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Blue Hill Cem Annapolis Md Date Dec 9, 1939

19. UNDERTAKER Charles A. Alexander. (Address) Annapolis Md

20. FILED Dec 7, 1939 Clara M. Harlan Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 6th, 1939 (Month) (Day), 193 (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ; I last saw h alive on , 19 ; death is said to have occurred on the date stated above, at 5.50 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Chronic Myocarditis | Date of onset

Other Contributory Causes of importance: Hypostatic Pneumonia

Name of operation — Date of —

What test confirmed diagnosis? Lungs fellow up Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury — , 19 —

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Thos. W. Phillips M. D.

(Address) Jessup Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE [illegible]LY, WITH UNFADING INK—THIS IS A PERMANENT RECO[illegible] Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

11683

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Brooklyn
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 1/2 Hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A A Co

City or town Brooklyn Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Wasina + Church st
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rose M Budahazy

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 5 1939

8. AGE: Years | Months | Days | If less than one day 2 1/2 hrs. min.

9. Birthplace Brooklyn Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name John Budahazy
13. Birthplace Baltimore

MOTHER
14. Maiden name Emma K Gischel
15. Birthplace Curtis Bay

16. Informant John Budahazy
Address Wasina + Church st

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 6 1939 (month) (day) (year)

Cemetery or crematory Holy Cross Cemetery

Location Brooklyn Md

18. Funeral director William M Marcek
Address 715 Light St

19. Dec 6 1939 (Date rec'd by registrar) Ida M Whelan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1939, at 7 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1939, to Dec 5 1939, and that I last saw her alive on Dec 5 1939.

Immediate cause of death Asphyxia Neonatorum

Due to Atelectasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2 1/2 hr.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leon J. Horka M. D.
M. D. or other

Address 4700 Pennington Ave Date signed 12/6/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (160-B) Reg. Dist. No. 23

CERTIFICATE OF DEATH

11684

1. PLACE OF DEATH:

(a) County Anne Arundel

(b) City or town Linthicum Md (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Maple Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 14

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Aa

(c) City or town Linthicum (If outside city or town limits, write RURAL and give town)

(d) Street No. Maple Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Charles Frank Burgess

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single —

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4 - 1939

8. AGE: Years | Months | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore - Md - (Town, county, and state)

10. Usual occupation None

11. Industry or business —

FATHER

12. Name Frank Burgess

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Emma Uhler -

15. Birthplace Baltimore

16 (a) Informant Mrs Frank Burgess

(b) Address Maple Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 1939 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director John Ullrich

(b) Address 2008 Orleans St.

19 (a) 19 Dec 1939 (Date rec'd by registrar) (b) Caldwell Woodruff Jr. Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 18 1939, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1939, to Dec. 18 1939, and that I last saw him alive on Dec. 18 1939.

Immediate cause of death Haemorrhage from jaw — Duration 1 week

Due to Apparently injured rt. jaw causing Haematoma in rt. — Dec. 11-1939

Due to Check with Bleeding - at Volunteers of America Hosp. was

Other conditions taken home against wish of hospital — (Include pregnancy within 3 months of death)

Major findings:

Of operations Probably accidental injury in delivery - C.O.S.

Of autopsy No further information

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident ??

(b) Date of occurrence Dec. 11 - 1939

(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hosp. (Specify type of place) While at work? —

(e) Means of injury Unknown —

23. Signature Chas. L. Ball Jr. MD. M. D. or other

Address Linthicum Date signed Dec. 19 1939.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

11685

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 yrs. 9 mos, 16 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 631 N. Carey Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: GEORGE CARTER

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	black	married

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years	Months	Days	If less than one day
79	Unknown		hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Farmer-Sailor
11. Industry or business: -----

FATHER
12. Name: George W. Carter
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Wooten
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1939 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore, Maryland

18. Funeral director: Joseph A. Livly
Address: 409 N. Mount St., Balto.

19. 14 Dec 1939 (Date rec'd by registrar) Baldwin Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13th 1939, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. Feb. 27th 1936, to Dec. 13th 1939, and that I last saw him alive on Dec. 13th 1939.

Immediate cause of death: Arteriosclerotic brain disease — DURATION:
Due to:
Due to:
Other conditions: Senile dementia
(Include pregnancy within 3 months of death)
Major findings: -----
Of operations:
Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ---- Date of:
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: ------ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 12/13/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11686

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.

City or town Annapolis.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 23 day's

Stay in this community (yrs., or mos., or days) 3 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 104 Monticello Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

John Alvin Wayne Clark

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1939

8. AGE:

Years	Months	Days	If less than one day
	3 2	29	hrs. min.

9. Birthplace Annapolis
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Leonard A. Clark. Jr
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden name Stella L. Owens
15. Birthplace Maryland

16. Informant Lenard A. Clark.
Address 1o4 Monticello Ave. Annapolis,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 1939 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director B.L. Hopping

Address Annapolis, Md.

19. Dec 30th 1939 (Date rec'd by registrar) J.J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1939, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1939 to Dec 28 1939, and that I last saw him alive on Dec 28 1939.

	DURATION
Immediate cause of death: Bilateral Bronchopneumonia	4 hrs.
Due to: Influenza	Nov. 15
Due to: Malnutrition	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 12.29

RECEIVED
JAN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11687

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel — Registration Dist. No. 22

Village or City Jessup, Maryland. — No. House of Correction St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. — How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Arthur Clevelana — If U. S. Veteran, specify WAR ...

(a) Residence: No. 5 Bethel St. Cambriage Mass, Ward. S. S. No. 1-212-14-4082 Mass.
(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Colored	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) May 27, 1901

7. AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	38	7	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ...

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Barber

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) Americus
(State or country) Georgia.

FATHER

13. NAME Amos Clevelana

14. BIRTHPLACE (city or town) Unknown
(State or country)

MOTHER

15. MAIDEN NAME Emma Mann

16. BIRTHPLACE (city or town) Unknown
(State or country)

17. INFORMANT Emma Mann, (Mother)
(Address) c/o Hugh Page, Route #2

18. BURIAL, CREMATION, OR REMOVAL Cherry Hill Americus, Georgia,
Place ... Date Jan 5, 1940

19. UNDERTAKER J. L. Collins
(Address) Jessup, Md.

20. FILED Jan 5, 1940 Clarence Haslett
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 27th, 1939
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 2nd, 1939, to Dec. 27th., 1939
I last saw him alive on Dec. 27th, 1939; death is said to have occurred on the date stated above, at 1.50 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Prior to	1938
Pulmonary Tuberculosis	

Other Contributory Causes of Importance:

Name of operation X Date of ...

What test confirmed diagnosis? X Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ...
(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.
...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ...
(Signed) Thos. H. Phillips M. D.
(Address) Jessup, Maryland.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED FEB 6 1940 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Information obtained from case history Dadd
place of death. 2/16/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

11688

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 yrs. 2 mos. 1 da.
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Colesville Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: EFFIE WILSON CRUMP

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

8 (b) Name of husband or wife: ------

6(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years	Months	Days	If less than one day
38	Unknown		------ hrs. ------ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ------

FATHER — 12. Name: Sam Wilson
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Cook
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15. 1939 (month) (day) (year)

Cemetery or crematory: Linden Cemetery

Location: Linden, Md. Montgomery County

18. Funeral director: Robert L. Snowden

Address: Rockville, Md.

19. 12/12 (Date rec'd by registrar) 39 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11th 1939, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10th 1936, to Dec. 11th 1939, and that I last saw her alive on Dec. 11th 1939

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to	
Other conditions: Broncho pneumonia	

(Include pregnancy within 3 months of death)

Major findings: ------

Of operations:

Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of:
Where did injury occur? ------ (City or town) (County) ------ (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work? ------

23. SIGNATURE: Hal T. Snowden M. D. or other
Address: Crownsville, Maryland Date signed: 12/11/39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (84)

CERTIFICATE OF DEATH

11689

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 13 days
Stay in this community (yrs., or mos., or days) 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Unknown County Baltimore City
City or town Baltimore Ward No. --
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 752 W. Mulberry Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR -------

3. (a) FULL NAME Lois Davis

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Black
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Unknown
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): 1902
8. AGE: Years 37 Months Unknown Days If less than one day --- hrs. --- min.
9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: ------
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville State Hospital
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1939 (month) (day) (year)
Cemetery or crematory: Pleasant Hill
Location: South Carolina
18. Funeral director: DeLilly and Bailey
Address: 923 Third St., N.W. Wash. D.C.
19. 12/28 (Date rec'd by registrar) 1939 E. F. Joyce DL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1939, at 1:20 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 1939, to December 27 1939, and that I last saw her alive on December 27 1939.

Immediate cause of death: Manic Exhaustion
Due to ---
Due to -----
Other conditions ------
(Include pregnancy within 3 months of death)
Major findings:
Of operations -------
Of autopsy -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ---- Date of ----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Crownsville, Md. Date signed 12/27/3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11690

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Stony Creek
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: a. a.
City or town: Stony Creek Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: unnamed premature infant Dixon
3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	Negro	

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 13-1939, 1 pm.

8. AGE: Years: — Months: — Days: 4 If less than one day: hrs. min.

9. Birthplace: same (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: James R. Mahoney
13. Birthplace: Md.

MOTHER
14. Maiden name: Jeannette Dixon
15. Birthplace: Md.

16. Informant: Vera Mahoney
Address: P.O. Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-39 (month) (day) (year)
Cemetery or crematory
Location: Stony Creek

18. Funeral director: Jas. R. Mahoney
Address: " " "

19. 12-13 19 39 L. A. Breit
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 19 39, at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19

Immediate cause of death	DURATION
Stillbirth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. A. Breit, M.D.
Address: Pasadena, Md. M. D. or other
Date signed 12-13-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (47-B)

Reg. Dist. No. 21

11691

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Long Point (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 30 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County a. a.
(c) City or town Long Pt. P.O. Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alexander Charles Fick

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Mary Fick

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1857

8. AGE: Years 82 | Months 2 | Days 23 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Retired Fisherman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name "
15. Birthplace " "

16 (a) Informant Milton Fick
(b) Address P.O. Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8-39 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Laurel Md.

18 (a) Funeral director Wm. Cook
(b) Address Balto. Md

19 (a) 12-5-39 (Date rec'd by registrar) (b) L. A. Brit Registrar

MEDICAL CERTIFICATION

20. Date of death December 5 1939 at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1939, to Dec. 5 1939
and that I last saw him alive on Nov. 30 1939

Immediate cause of death	Duration
Pulmonary Carcinoma	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Brit, M.D. (M. D. or other)
Address Pasadena, Md. Date signed 12-5-39

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92a)

CERTIFICATE OF DEATH

11692

Reg. Dist. No. 2-2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Ft. Meade - Odenton line
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Stony Hill
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Cecil F. Gilmore
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife: Margaret E. Gilmore
6(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1910

8. AGE:

Years	Months	Days	If less than one day
29	4	9	hrs. ____ min.

9. Birthplace: Moundsville, W. Va.
(Town, county, and state)
10. Usual occupation: Cashier, Commissary
11. Industry or business: Ft. Meade
FATHER 12. Name: Harry Lee Gilmore
FATHER 13. Birthplace: West Virginia
MOTHER 14. Maiden name: Minnie May Wood
MOTHER 15. Birthplace: West Virginia
16. Informant: Mrs. Margaret E. Gilmore
Address: Odenton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 13 1939 (month) (day) (year)
Cemetery or crematory: Nicholas Memorial
Location: Glendale, Md.
18. Funeral director: Floyd Bauser
Address: Laurel, Md.
19. Dec 12 1939 (Date rec'd by registrar) N. L. Jones D. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 1939, at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1938 to Dec 1 1939, and that I last saw h[illegible] alive on Dec 9 1939.

Immediate cause of death	DURATION
Acute myocardial failure	½ hour
Due to	
Due to Chr. valvular disease	1 year 10 months
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D.
M. D. or other
Address: Annapolis Date signed 12/11/39

RECEIVED
JAN 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

11693

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 84 Prince George St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George H. Hahn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kate Hahn

6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 30. 1873

8. AGE:

Years	Months	Days	If less than one day
67	8	18	hrs. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Captain (Watchman)

11. Industry or business U.S. Naval Academy

FATHER 12. Name George H. Hahn

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Kate Hahn

Address Annapolis Md.

17. Burial Date thereof Dec 21st 1939

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Marys

Location Annapolis Md.

18. Funeral director John W. Taylor

Address Annapolis Md.

19. 12 19 1939 J. H. Murphy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1939, at 2a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 1939, to Dec 18 1939, and that I last saw him alive on 12-18 1939.

	DURATION
Immediate cause of death Coronary Thrombosis	30 hrs.
Due to Arteriosclerosis C.V.D.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Eastport, Md Date signed 12-18-39.

RECEIVED
JAN 6 1940
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 27 — 11694

1. PLACE OF DEATH:
County A. A.
City or town Skidmore Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Skidmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Carrie D. Harris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colred	married

B (b) Name of ~~husband~~ or wife Frank Harris

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec. 3 1902

8. AGE: Years 37 | Months 0 | Days (1) | If less than one day ____ hrs. ____ min.

9. Birthplace Skidmore
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Arthur Green
13. Birthplace Skidmore Md

MOTHER
14. Maiden name Rachiel Hankesmond
15. Birthplace Skidmore Md

16. Informant Frank Harris
Address Skidmore Md.

17. Burial Date thereof Dec. 7 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Broadneck
Location St. Margrettes

18. Funeral director J. B. Truman
Address Annapolis

19. 12 7 1939 J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1939, at 2.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1939, to Dec 4 1939, and that I last saw her alive on Dec. 3 1939.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions Malnutrition	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M. D. or other
Address Annapolis Md Date signed 12/6/39

MARGIN RESERVED FOR BINDING

PRINT IN WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3)

11695

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1yr. 2mo. 14days

Stay in this community (yrs., or mos., or days): 1yr. 2mo. 14days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infanta give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge, Maryland Ward No.: --
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 144 Washington Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---------

3. (a) FULL NAME: Claude Platen Henry

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

----- 6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years: 40 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER
12. Name: Jason Henry
13. Birthplace: Maryland

MOTHER
14. Maiden name: Willie Platen
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 3, 1939 (month) (day) (year)

Cemetery or crematory: Old Field Cemetery

Location: Cambridge, Maryland

18. Funeral director: Louis H. Bayneum

Address: Cambridge, Maryland

19. 12 1st 1939 (Date rec'd by registrar) J. J. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st 1939, at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 16, 1938, to December 1 1939, and that I last saw him alive on December 1st 1939.

Immediate cause of death: General Paresis

Due to:

Due to:

Other conditions: Diabetes

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ------

Of autopsy: ------

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of: ----

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work?

23. SIGNATURE: Robert P. Winterode
M. D. or other

Address: Crownsville, Md. Date signed: 12/1/39

RECEIVED
DEC 14 1939
BUREAU V. S.

Dr. Murphy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107-a)

CERTIFICATE OF DEATH

11696

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
1001 West ST.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 mo. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A. Co.
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1001 West ST.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Jane Holmes

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct. 10, 1939
8. AGE: Years ____ Months 2 Days 12 If less than one day ____ hrs. ____ min.
9. Birthplace Annapolis (town, county, and state)
10. Usual occupation none
11. Industry or business none
FATHER 12. Name Oliver Holmes
13. Birthplace West Virginia
MOTHER 14. Maiden name Mildred Asquith
15. Birthplace A. A. Co. Md.
16. Informant Mildred Holmes
Address Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 24, 1939 (month) (day) (year)
Cemetery or crematory All Hallows
Location A. A. Co. Md.
18. Funeral director John M. Taylor
Address Annapolis, Md.
19. Dec 24 1939 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1939, at 4A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-21 1939, to 12-22 1939, and that I last saw her alive on 12-21 1939

Immediate cause of death	DURATION
Bilateral Bronchial pneumonia	12-21
Due to cold	12-19
Due to	
Diher conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Basil M. D. or other
Address Annapolis Md Date signed 12-24

RECEIVED
JAN 8 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

11697

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 years 3 month's

Stay in this community (yrs., or mos., or days): " "

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 216 E. Madison St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ----------

3. (a) FULL NAME: Raymond Holton

3. (b) Social Security Number:

4. Sex: male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida Holton

unknown

6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): 1918

8. AGE: Years: 21 Months: unknown Days: - If less than one day: ---- hrs. ---- min.

9. Birthplace: N. Carolina
(Town, county, and state)

10. Usual occupation: plummer

11. Industry or business: -------

FATHER
12. Name: John Holton
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Littie Holton
15. Birthplace: unknown

16. Informant: Hospital records

Address: Crownsville State Hospital

17. burial
(Burial, cremation, or removal. Which?)

Date thereof: 1/4 - 40 (month) (day) (year)

Cemetery or crematory: Mt Calvary County

Location: A. A. Co

18. Funeral director: Bayhan & Mannicaut Jr

Address: 1219 McFaddey St

19. Dec 31 1939 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1939, at 9:35 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 1937, to Dec. 30 1939, and that I last saw him alive on dec. 30 1939.

Immediate cause of death: general paresis

DURATION: unknown

Due to: syphilis

Due to: 6 ---------

Other conditions: ----------

(Include pregnancy within 3 months of death)

Major findings: ----------

Of operations: ----------

Of autopsy: ----------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of: -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ----- Injured at work? -------

23. SIGNATURE: Joseph P. Whitehead
M. D. or other

Address: Date signed: 12/30/39

RECEIVED
JAN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

11698

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County A. A.
City or town Jones
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Jones Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alberta Hunt

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
B (b) Name of husband or wife
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Nov. 1 1918
8. AGE: Years: 21 Months: 1 Days: 9 If less than one day: ____ hrs. ____ min.
9. Birthplace: Jones A. A. Co. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Charles Hunt
13. Birthplace: A. A.
MOTHER 14. Maiden name: Alberta Barnes
15. Birthplace: A. A.
16. Informant: Albert Hunt
Address: Jones
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 14 39 (month) (day) (year)
Cemetery or crematory: Carpenter's Hill Cem.
Location: Jones
18. Funeral director: J. B. Johnson
Address: Annapolis
19. Dec 13th 19 39 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1939 at 11:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/9/38 19__ to 12/10/39 19__, and that I last saw h__ alive on 12/10/39 19__.

	DURATION
Immediate cause of death	
Due to Pulmonary Tuberculosis	9/9/38
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Carpenter M. D. or other
Address John Burnett M.D. Date signed

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

11699

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural near Laurel
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: District Training School
Stay in hospital or inst. (yrs., or mos., or days): 12 years
Stay in this community (yrs., or mos., or days): 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: No address; No relatives; Committed to institution from D.C. on 1927
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Gertrude Jackson

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: Col
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 22, 1914

8. AGE: Years: 25 Months: 10 Days: 28 If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: None - Institution Inmate
11. Industry or business:
FATHER
12. Name: Jack Anderson (?) Pt. illegitimate
13. Birthplace: Unknown
MOTHER
14. Maiden name: Agnes Jackson
15. Birthplace: Unknown
16. Informent: Institution Records
Address: District Training School, Laurel.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 20-39 (month) (day) (year)
Cemetery or crematory: Dist Training School
Location: near Laurel Md.
18. Funeral director: Dist Training School Officials
Address: Laurel Md
19. Dec 19 1939 (Date rec'd by registrar) Clara M Hanlup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1939, at 8 45 a.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1935, to December 19 1939, and that I last saw her alive on December 18 1939.
Immediate cause of death: Burns, Accidental, sustained on Nov 17, 1939
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: No operation
Of autopsy: No autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident Date of: Nov 17, 1939
Where did injury occur? Laurel (Rural) (City or town) Anne Arundel (County) Maryland (State)
Injured at home, farm, industry, public place (where?): In institution
Means of injury: See Back Injured at work? No

23. SIGNATURE: E J Alexander MD. M. D. or other
Address: Dist Tr. School Laurel Date signed: 12-19-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Patient made a fire of newspapers in a room,
+ accidentally caught her nightgown on fire

RECEIVED
JAN 9 1919
BUKE U V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

11700

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 116 Calvert St. Annapolis Md.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 116 Calvert
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Francis Johnson

3. (b) Social Security Number None

WITHIN CORPORATE LIMITS

4. Sex: Female
5. Color or race: Col
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or ~~wife~~: Horace Johnson
6(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.): June 8 1887
8. AGE: Years 52, 52 Months 6 Days 19 If less than one day ___ hrs. ___ min.
9. Birthplace: Hawdsonville Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: X
FATHER
12. Name: Joseph Simpson
13. Birthplace: Hawdsonville Md.
MOTHER
14. Maiden name: Menerwa Johnson
15. Birthplace: Hopes Chapel Md.
16. Informant: Horace Johnson
Address: 116 Calvert St Annapolis Md.
17. (Burial, cremation, or removal. Which?) Date thereof: Dec. 31 39 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: on Washington Rd outside City
18. Funeral director: Chas H Alexander
Address: 43, 45 Northwest St.
19. Dec 31 1939 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1939, at ___ M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1939, to Dec 26 1939, and that I last saw her alive on Dec 26 1939.

Immediate cause of death	DURATION
Chr. Myocarditis - Decompensated	
Due to	
Due to	
Other conditions: Auricular fibrillation (Include pregnancy within 3 months of death)	12/27

Major findings:
Of operations
Of autopsy: none done.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ___ Date of ___
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE: M. F. Khawans, M.D. or other
Address: 31 Smithgate Av Date signed: 12/28/39

RECEIVED
JAN 6 1940
BUREAU V. S.

11701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Waterbury

Stay in hospital or inst. (yrs., or mos., or days): 37 yrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: A A Co

City or town: Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John T. Johnson

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: B

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarah Well Johnson

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 20 - 1860

8. AGE: Years 79 Months 6 Days 10 If less than one day ____ hrs. ____ min.

9. Birthplace: Anne Arundel Co Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Wm H Johnson

13. Birthplace: A A Co Md

MOTHER 14. Maiden name: Mary Ellen Hopkins

15. Birthplace: A A Co Md

16. Informant: W H Johnson

Address: 1904 3d St Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4 1939 (month) (day) (year)

Cemetery or crematory: Cross Road Cemetery

Location: Near Waterbury Md

18. Funeral director: Charles H. Alexander

Address: Annapolis Md

19. Dec 2 1939 (Date rec'd by registrar) W. L. Jones D. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 - 39, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1939, to Dec 1 - 1939 and that I last saw ___ alive on Dec 1 - 1939.

Immediate cause of death: Lobar Pneumonia

Due to

Due to: Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Clinton Md Date signed Dec 1 - 39.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CEIVED
JAN 9 1940
BAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11702

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15 yrs. 7 mos. 14 days

Stay in this community (yrs., or mos., or days): -------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Unknown Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: LINWOOD STOKES KING

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6 (b) Name of husband or wife: -------

6(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1908

8. AGE: Years	Months	Days	If less than one day
31	Unknown		----- hrs. ----- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: -----

FATHER — 12. Name: Henry King

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Elliott

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-9-9 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address

19. Dec 9 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5th 1939, at 6A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22nd 1924, to Dec. 5th 1939, and that I last saw him alive on Dec. 5th 1939.

Immediate cause of death	DURATION
Bilateral pulmonary tuberculosis	18 mos
Due to	
Due to	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ------

Of autopsy: ---------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur?: ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ------ Injured at work?

23. SIGNATURE: Robert B. Winterode M. D. or other

Address: Crownsville, Md. Date signed: 12/5/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

State of Md.

HEALTH DEPARTMENT—~~CITY OF BALTIMORE~~

11703

CERTIFICATE OF DEATH (74E)

1. PLACE OF DEATH

Registered No. 21

CITY OF ~~BALTIMORE~~ ANNAPOLIS: (No. 16 RIDGEWOOD AVE St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? 50 yrs. ..... mos. ..... ds.

2. FULL NAME Nathan Klawans

If U. S. Veteran specify WAR .....

(a) Residence: No. 16 Ridgewood Av St., ... Ward. .....
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	M.

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Ida Mervis Klawans

6. DATE OF BIRTH (month, day, year) unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Merchant.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Kovna Lithuania

FATHER

13. NAME Abraham Isaac Klawansky

14. BIRTHPLACE (city or town) (State or country) Kovna Lithuania

MOTHER

15. MAIDEN NAME unknown.

16. BIRTHPLACE (city or town) (State or country) Kovna

17. INFORMANT M. I. Klawans, (Address) 31 South Gate Av.

18. BURIAL, CREMATION, OR REMOVAL Place Mikro Kodish Date 12-3-39, 19

19. UNDERTAKER Jack Lewis Jr. (Address) 1439 E. Baltimore

20. FILED 12 2, 1939 J. J. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. ~~Dec~~ 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1939 to Dec 1, 1939

I last saw him alive on Dec 1, 1939. Death is said to have occurred on the date stated above, at 12:30 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	11/25/39

Other contributory causes of importance:

Ac. Pulmonary Edema	12/1/39

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Maurice I. Klawans, M. D.

(Address) 31 South Gate Av.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M. D. R. 1268-9

STATE OF MARYLAND—CERTIFICATE OF DEATH

11704

MARGIN RESERVED FOR BINDING

N. B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (940)

County Anne Arundel Registration Dist. No. 22

Village or City Jessup, Maryland. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Fred Leonard If U. S. Veteran, specify WAR

(a) Residence: No. None St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) March 11th, 1873

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
66	9	10	15 hrs. 5 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Unknown

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Berlin, Germany
(State or country)

FATHER

13. NAME Herman Leonard

14. BIRTHPLACE (city or town) Unknown
(State or country)

MOTHER

15. MAIDEN NAME Henrietta Bucholz

16. BIRTHPLACE (city or town) Unknown
(State or country)

17. INFORMANT Records of Md. House of Correction
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Cherry Hill Date Jan 6, 1940

19. UNDERTAKER N. L. Collins
(Address) Jessup Md

20. FILED Jan 30, 1940 Clara M. Hasler
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH
December 22nd, (Month) (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attendad deceased from
, 19 , to , 19
I last saw h alive on , 19 ; death is said
to hava occurred on the date stated abova, at 3.05 P.M.

The **PRINCIPAL CAUSE OF DEATH** and ralated causes of importance were as follows:

	Date of onset
	12-22
Coronary Thrombosis	
Cardiac Asthma	
Othar **Contributory Causes** of importance:	
Bronchial Asthma	1

Name of operation Date of
What test confirmed diagnosis? Was thera an autopsy?

23. If death was due to external causas (VIOLENCE) fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Whera did Injury occur?
(Specify city or town, county and State)
Spacify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE.
Manner of injury
Nature of injury

24. Was disaase or injury in any way ralated to occupation of deceased?
If so, specify
(Signed) Thos. H. Phillips M. D.
(Address) Jessup, Maryland.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92E)

CERTIFICATE OF DEATH

11705

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 89 Prince George St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 89 Prince George (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jannie A. Le Tourneau

3. (b) Social Security Number

WITHIN CORPORATE LIMITS OF

4. Sex: Female

5. Color or race: Volute

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry F. Le Tourneau

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feby 8th ~~1889~~ 1880

8. AGE: Years 59 Months 10 Days 9 If less than one day ____ hrs. ____ min.

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: John C. Hipkins

13. Birthplace: Baltimore Md.

MOTHER

14. Maiden name: Elizabeth Brooks

15. Birthplace: Annapolis Md.

16. Informant: Harry F. Le Tourneau

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 20th 1939 (month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 12 19 1939 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1939, at 1 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from May 29 1939, to Dec 17 1939, and that I last saw h[illegible] alive on Dec 1939.

Immediate cause of death: Myo-Endo Carditis with fribillation — DURATION: several months

Due to: Arterial Hypertension

Due to

Other conditions: Arterial hypertension — a year or more

(Include pregnancy within 3 months of death)

Major findings:

Df operations

Df autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J Oliver Purvis M. D. or other

Address: Annapolis Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(I)

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JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1646)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: South River Bridge, State Route 214, Anne Arundel Co., Maryland.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 7months; 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: U. S. Naval Academy
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Robert Lee LOVE

3. (b) Social Security Number: - - - - - -

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mrs. Robert L. Love. 3621 Newark St. N.W. Washington, D.C.

6(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): March 2, 1914

8. AGE:

Years	Months	Days	If less than one day
25	9	11	hrs. min.

9. Birthplace: Missouri
(Town, county, and state)

10. Usual occupation: U. S. Navy.

11. Industry or business: Lieut. (junior Grade) (Dental Corps), U.S. Navy.

FATHER
12. Name: William Spencer Love.
13. Birthplace: Tennessee.

MOTHER
14. Maiden name: Addie McCall
15. Birthplace: Tennessee.

16. Informant: Mrs. Robert L. Love,
Address: 3621 Newark St., N.W., Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 26 1940 (month) (day) (year)

Cemetery or crematory: Arlington

Location: Arlington, Va.

18. Funeral director: B.L. Hopping
Address: Annapolis, Md.

19. 3 26 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 December, 1939, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem to Examination 19 ~~and that I last saw h alive on~~ March 24 1940.

Immediate cause of death	DURATION
Due to Suicide	12/13/39
Due to Drowning	12/13/39
Other conditions Insanity	1939

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None performed
Of autopsy: None performed

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 12/13/39

Where did injury occur? Off South River Bridge A.A. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): South River

Means of injury: Drowning Injured at work? —

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md Date signed: 3/25/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 5 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

11706

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Weems Creek, Annapolis

(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: near Beats Gate Rd. (BEST GATE Road.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (R.F.D.) Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: near Beats Gate Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Machovsky

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	S

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1939

8. AGE: Years | Months | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Weems Creek, Annapolis Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: James Machovsky

13. Birthplace: Barfield, Md

MOTHER — 14. Maiden name: Ocie Blankenship

15. Birthplace: Dell, Virginia

16. Informant: James Machovsky

Address: Weems Creek, Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 25 1939 (month) (day) (year)

Cemetery or crematory: Wells View

Location: Weems Creek

18. Funeral director: B.L. Hopping

Address: Annapolis, Maryland.

19 Dec 25th 1939. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1939, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem to examination and that I last saw h alive on 19

	DURATION
Immediate cause of death: Cancenital debility	sudden
Due to: 5 lbs. baby at birth (full term)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John M. Claffy Deputy Medical examiner M. D. or other

Address: Annapolis Date signed 12/24/39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

11707

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County H. A.

City or town Annapolis, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County H. A.

City or town Annapolis Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 72 Washington

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Howard A. Mobray

3. (b) Social Security Number Never had Army

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1901

8. AGE: Years 38 Months 5 Days 3 If less than one day hrs. min.

9. Birthplace Annapolis Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Albert Mobray

13. Birthplace Annapolis

MOTHER 14. Maiden name Susil Johnson

15. Birthplace Annapolis

16. Informant Susil Mobray

Address 72 Washington St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 26/39 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis

18. Funeral director J B Johnson

Address Annapolis

19. 12 26 1939 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1939, at 8:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1939, to Dec 22 1939, and that I last saw him alive on Dec 21 1939.

Immediate cause of death: Cerebral convulsions & coma — DURATION: 2 days.

Due to: Luetic epilepsy. — years.

Due to

Other conditions: Chronic valvular disease; Chr. nephritis ?

(Include pregnancy within 3 months of death)

Major findings:

Of operations none.

Of autopsy none.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans Md M. D. or other

Address 31 Southgate Av Date signed 12/24/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The (three) age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46B) Reg. Dist. No. 23

11708

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County A. A.
(b) City or town Ferndale
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 2nd Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 9 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2nd Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Robert Leroy Mueller

3 (b) If veteran, name war —

3 (c) Social Security No. 214-01-7030

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Elizabeth Mueller

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Jan 12 1900

8. AGE: Years 39 | Months 10 | Days 27 | If less than one day _____ hr. _____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Sales manager

11. Industry or business Groceries - Wholesale

FATHER
12. Name Jacob Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Walton
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen Mueller
(b) Address Ferndale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1939 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Baltimore Md.

18 (a) Funeral director P. W. Lamoreau
(b) Address 1003 W. Baltimore St.

19 (a) Dec. 9, 1939 (Date rec'd by registrar) (b) Matilda R. DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 9 1939, at 3:08 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 10 1939, to Dec. 9 1939, and that I last saw him alive on Dec. 9 1939

Immediate cause of death Cancer of Stomach — Duration 6-10-38

Due to Ulcer Stomach — Feb. 1938

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Ca. Stomach found upon operation Jun 10-1938
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Ball Jr. MD
M.D. or other

Address Linthicum Date signed Dec. 9-1939

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12286

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution 5 Maryland Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 5 Maryland
(If rural, give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lucy Morvell Clark Mumford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Edward L Mumford
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19th 1862

8. AGE:

Years	Months	Days	If less than one day
77	7		hrs. min.

9. Birthplace Clarksville Penn.
(Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Micajah Henry Clark
13. Birthplace Richmond Va

MOTHER
14. Maiden name Elizabeth Watt Kerr
15. Birthplace Va

16. Informant Mrs Morvell M Mullally
Address 5 Md. Ave. Annapolis Md.
17. Burial Date thereof Dec 22 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hollywood Cemetery
Location Richmond, Va
18. Funeral director John W. Taylor
Address Annapolis Md.
19. 12 20 1939 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19th December 1939 at 8:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 1939 to Dec 19 1939 and that I last saw h alive on Dec 19 1939.

Immediate cause of death Endocarditis Acute — DURATION 10 Days

Due to Prob. Infection Gall bladder

Due to

Other conditions Cerebral Hypertension Chronic & Cr. Arthritis — DURATION 4 Yr.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edwin Powers M. D. or other
Address Annapolis Md Date signed Dec 20/39

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JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

11709

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 4th Ave S. Extended
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4th Ave. Extended
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Ann Newton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow.

6 (b) Name of husband or wife Frederick H. Newton
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 8, 1865

8. AGE:

Years	Months	Days	If less than one day
74	7	28	____ hrs. ____ min.

9. Birthplace Churchill, Queenanns Co. Md (Town, county, and state)
10. Usual occupation Retired (Practical Nurse)
11. Industry or business

FATHER
12. Name John Crane
13. Birthplace Maryland

MOTHER
14. Maiden name Louise Cookshank
15. Birthplace Unknown —

16. Informant Mr. Frederick P. Newton
Address Glen Burnie, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Dec. 8, 1939 (month) (day) (year)
Cemetery or crematory Glenhaven Memorial Pk.
Location Glen Burnie, Md
18. Funeral director Thomas W Singleton
Address Glen Burnie, Md.

19. Dec. 8, 1939 (Date rec'd by registrar) MEDe alba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1939, at 1030 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30 1939 to Dec. 6. 1939, and that I last saw h[illegible] alive on DEC. 5 1939.

Immediate cause of death	DURATION
DIABETES MELLITUS	UNKNOWN
Due to	
Due to	
Other conditions CARBUNCLE	6 WKS

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (Stste)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Alexander M. D. ~~or other~~
Address Glen Burnie Date signed 12/6/39

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DEC 16 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

11710

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: X
Stay in hospital or inst. (yrs., or mos., or days): X
Stay in this community (yrs., or ~~mos., or days~~): 70 ~~70~~ years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: AA
City or town: Annapolis Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 103 Washington
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Allen Parker

3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: Col.
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of ~~husband~~ or wife: Mary Parker
6 (c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): Sept. 6 1866

8. AGE: Years: 73 Months: 3 Days: 20 If less than one day: hrs. min.

9. Birthplace: Owensville Md.
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: X

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mary Parker
Address: 105 Washington St.

17. (Burial, cremation, or removal. Which?) Date thereof: Dec. 29 1939 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: On Washington Rd. Outside Annapolis

18. Funeral director: Chas. H. Alexander
Address: 43, 45 Northwest St Annapolis Md.

19. 12 28 1939 (Date rec'd by registrar) J. J. Kemp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26th 1939, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19th 1939, to Dec 26th 1939, and that I last saw him alive on Dec 26th 1939.

Immediate cause of death: Cerebral Apoplexy — DURATION: 7 days.
Due to
Due to
Other conditions: Arterial Hypertension — 6 months
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: Annapolis, Md. Date signed: 12/27/39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

11711

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2yr. 6mo. 27days

Stay in this community (yrs., or mos., or days) 2yr. 6mo. 27days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 136 Carrollton Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ---

3. (a) FULL NAME

Annie Petro

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widowed

6 (b) Name of husband or wife Wm. Henry Alston

6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
60	Unknown		--- hrs. --- min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business ---

FATHER
12. Name George Brown
13. Birthplace Maryland

MOTHER
14. Maiden name Matilda Arthur
15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27, 1939 (month) (day) (year)

Cemetery or crematory Crownsville State Hospital

Location Crownsville, Maryland

18. Funeral director Supt.

Address

19. Dec 27 1939 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1939, at 8:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22nd 1937, to December 19 1939, and that I last saw her alive on December 19 1939.

Immediate cause of death	DURATION
Broncho Pneumonia	
Due to Fracture of the left femur due to an accidental fall. C.W.S.R.	
Due to ---	
Other conditions Patient slipped on the floor in the ward of the Hospital, October 12th, 1939.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy ---

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of October 12, 1939

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In Hospital

Means of injury --- Injured at work? ---

23. SIGNATURE Herbert Stansfeld M. D. or other

Address Crownsville, Md. Date signed 12/20/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11712

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 26 yrs. 6mos. 27das.
Stay in this community (yrs., or mos., or days): ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Unknown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: DREW PONS

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	BLACK	Single

6 (b) Name of husband or wife: ---
6 (c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: about 50 Unknown | Months: | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ---

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, ~~cremation, or removal~~. Which?) Date thereof 12/15-39 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.
Supt

18. Funeral director: ---
Address

19. Dec 15 1939 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10th 1939, at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13th 1913 to Dec. 10th 1939 and that I last saw her alive on Dec. 10th 1939.

Immediate cause of death: Chronic myocarditis and endocarditis — DURATION: 2 yrs.
Due to: ---
Due to: ---
Other conditions: Terminal right upper lobar pneumonia and left lower bronchial pneumonia — DURATION: 2 das.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: ---

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur?: --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work?

23. SIGNATURE: Hal D. Ironmonger M. D. or other
Address: Crownsville, Md. Date signed 12/10/39

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JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

11713

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville StateHospital

Stay in hospital or inst. (yrs., or mos., or days) 3yr.6mo.21days

Stay in this community (yrs., or mos., or days) 3yr.6mo.21days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Trappe Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ----------
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -------

3. (a) FULL NAME Stephen Potts

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Black

6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

----- 6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 24 Months Unknown Days If less than one day ---- hrs. ---- min.

9. Birthplace Trappe, Maryland, Talbot Co.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ------

FATHER
12. Name Stephen A. Potts
13. Birthplace Maryland

MOTHER
14. Maiden name Georgie (unknown)
15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30 1939 (month) (day) (year)

Cemetery or crematory

Location Trappe Md

18. Funeral director Maurice E. Newnam & Son

Address Easton Md.

19. Dec 29th 1939. (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1939, at 12:18P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1936, to December 28 1939, and that I last saw him alive on December 28 1939

Immediate cause of death: Pulmonary Tuberculosis

Due to ----

Due to -------

Other conditions -------

(Include pregnancy within 3 months of death)

Major findings:

Of operations -----

Of autopsy -------

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury --- Injured at work? ---

23. SIGNATURE [signature] M. D. or other

Address Crownsville, Md. Date signed 12/28/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11714

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 years 8 months

Stay in this community (yrs., or mos., or days): same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ~~Cha~~ Maryland County: Balto. Co.

City or town: Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: -----
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lester Preston

3. (b) Social Security Number

4. Sex: male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: ----------

6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 24 Months: -- Days: ---- If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: -------

FATHER
12. Name: George Preston
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Giles
15. Birthplace: Maryland

16. Informant: Hospital records

Address: Crownsville State Hospital

17. Buried
(Burial, cremation, or removal. Which?)

Date thereof: Jan. 6, 1940
(month) (day) (year)

Cemetery or crematory: Mt. Wilburn Cemetery

Location: Chase, Maryland

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder Street

19. Jan 2 1940 E. F. Joyce
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12.31.39. 19 , at 6 15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from april 30. 1937 to dec. 31. 1939, and that I last saw him alive on 12.30.39. 19

Immediate cause of death: Pulmonary Tuberculosis

Due to

Due to

Other conditions: left tubercular kidney removed in 1935
(Include pregnancy within 8 months of death)

Major findings:

Of operations: -------

Of autopsy: -------

DURATION: april 30.37. to dec. 31.39.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 12/31/39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

11715

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 213 Gloucester St.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 213 Gloucester St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mary Pearson Read

3. (b) Social Security Number

WITHIN CORPORATE LIMITS OF

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 25 1861

8. AGE:

Years	Months	Days	If less than one day
78	·	18	— hrs. — min.

9. Birthplace Lynchburg Va
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name John Alexander Read
13. Birthplace Lynchburg Va

MOTHER
14. Maiden name Emma White
15. Birthplace Lynchburg Va

16. Informant Mrs Lottie Read Lockwood
Address 213 Gloucester St. Annapolis Md

17. Burial Date thereof Dec 14th 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md

18. Funeral director John W. Taylor
Address Annapolis Md.

19. 12 13 1939 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1939, at 4 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1938, to Dec 12 1939
and that I last saw h-- alive on Dec 12 1939.

Immediate cause of death	DURATION
(a) Myocarditis	1 yrs
(b) Nephritis	4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE J J Murphy M. D. or other
Address Annapolis Md Date signed 12 13 39

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JAN 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-E)

11716

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A

City or town Rural near Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Rural near Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Fairfax
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hilbert W. Reinken

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

B (b) Name of husband or wife Mary C. Reinken

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9 1863

8. AGE: Years	Months	Days	If less than one day
76	10	20	hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Reinken
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace unknown

16. Informant Louis A. Rose

Address Annapolis, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1940 (month) (day) (year)

Cemetery or crematory Edwards Chapel

Location Parole, Md

18. Funeral director B.L. Hopping

Address Annapolis, Md.

19. 1 2 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1939, at 10.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1939, to Dec 12 1939, and that I last saw him alive on Dec 11 1939.

Immediate cause of death	DURATION
Ac. Pulmonary Edema	12/11/39
Due to Chr. Myocarditis	?
Due to ~~Chr.~~ Senility	
Other conditions Chr. Nephritis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, Md
M. D. or other

Address 31 Smith Gate Av Date signed 1/1/40

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FEB 5 1940
BUREAU V. S.

11717

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (144C)

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A.

City or town Near Laurel Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A. A.

City or town Near Laurel Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Trenhild O. Richardson

3. (b) Social Security Number

4. Sex F

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emmett Richardson

6(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Dec 16th

8. AGE: Years 34 35 Months 11 Days 17 If less than one day ___ hrs. ___ min.

8. Birthplace Sweden (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Unknown

13. Birthplace Sweden

MOTHER 14. Maiden name "

15. Birthplace "

18. Informant Emmett Richardson

Address Odenton R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4. 1939 (month) (day) (year)

Cemetery or crematory Ivy Hill

Location Laurel Md.

18. Funeral director Lloyd Kaiser

Address Laurel Md

19. Dec 4 1939 (Date rec'd by registrar) Clara M Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1939, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1933, to Dec 2 1939, and that I last saw her alive on Dec 2 1939.

Immediate cause of death Eclampsia (fulminating) — DURATION 1 day

Due to Pregnancy at term

Due to

Other conditions Post partum hemorrhage — 1 day

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S McCeney M.D. M. D. or other

Address Laurel Md Date signed 12/4/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 9 1940
BUREAU V. S.

Dr. Alexander Glenburnie 134

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

11718

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: A A Co

City or town: Severn
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 56 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A.A.Co.

City or town: Severn Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Emil Herman Schultz.

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. ~~(a) Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Sophia Schultz

6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): April 26th 1863

8. AGE: Years: 76 Months: 7 Days: 16 If less than one day: ____ hrs. ____ min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Husbandry

FATHER
12. Name: Schultz
13. Birthplace: Unknown

MOTHER
14. Maiden name: "
15. Birthplace: Germany

16. Informant: Sophia Schultz

Address: Severn Md

17. Burial
(Burial, ~~cremation, or removal. Which?~~)
Date thereof: 12/15/39 (month) (day) (year)

Cemetery ~~or crematory~~: Friendship

Location: A. A. Co. Md

18. Funeral director: William Cook

Address: 1217 St. Paul St

19. Dec. 14 1939 (Date rec'd by registrar) Mrs DeAlva Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12th 1939, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7th 1939, to Dec 11th 1939, and that I last saw h____ alive on Dec 11th 1939.

Immediate cause of death: Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: John J. Alexander M. D. or other

Address: Glen Burnie Date signed: 12/13/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 8 1940
BUREAU V. S.

11719

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gotts Sta. Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 6 mos 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Herald Harbor Rd, near Gotts Sta.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Walter Lake Dewell.

3. (b) Social Security Number: 212-05-4754

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Carrie Irene Dewell
6(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): July 5, 1890

8. AGE: Years 49 Months 4 Days 25 If less than one day ___ hrs. ___ min.

9. Birthplace: St. Michaels, Talbot Co. Md
(Town, county, and state)
10. Usual occupation: Photographer
11. Industry or business: Gas and Electric Co. Balto.

FATHER
12. Name: Walter M. Dewell
13. Birthplace: St. Michaels, Maryland

MOTHER
14. Maiden name: Ellen Madigan Blades
15. Birthplace: St. Michaels, Md

16. Informant: Mrs. Carrie I. Dewell
Address: Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5/39 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore Md

18. Funeral director: William Cook
Address: 1217 St Paul St

19. 12/2 (Date rec'd by registrar) 19 E. F. Joyce D.P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1. 1939, at 9:10 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem examination and that I last saw h___ alive on ___ 19___.

Immediate cause of death	DURATION
Coronary Occlusion	sudden death
Due to Arterial Hypertension	2 years
Due to Chronic nephritis	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ___ Date of ___
Where did injury occur? ___ (City or town) ___ (County) ___ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other
Address: Annapolis Md Date signed: 12/1/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Mrs Emma Sewell
St Michaels Md
Lake dead to-night
at 9:10 P.M. Sud.
Burial in Balto
Staying at Ellas
Phone Chesapeake 6307
Sign
Carrie.

RECEIVED
DEC 29 1939
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11720

11-a

1. PLACE OF DEATH

County A. A. Co. Registration Dist. No. 20

Village or City Lothian Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Hugh Melvin Simms If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Boy	Col	Single

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) April 6 1939.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Lothian

(State or country) A. A. Co. Maryland

FATHER

13. NAME Walter Simms

14. BIRTHPLACE (city or town) Friendship

(State or country) A. A. Co. Md.

MOTHER

15. MAIDEN NAME Edsie Parker

16. BIRTHPLACE (city or town) Birdsville

(State or country) A. A. Co. Md.

17. INFORMANT Walter Simms

(Address) Lothian Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Adams Chapel Date 12/4 1939

19. UNDERTAKER T. H. Hardesty & Son

(Address) Galesville. Md.

20. FILED 12/2 1939 H. R. Clayton

Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 2nd 1939

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov. 28 1939, to December 2, 1939

I last saw him alive on December 1st 1939; death is said to have occurred on the date stated above, at 10:40 A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Broncho Pneumonia	Nov 26 1939
Secondary	
La Grippe	7

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to externaf causes (VIOLENCE) fill in also the folfowing:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Neture of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) F. B. Yeast M. D.

(Address) Lothian, Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11721

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 4 yrs. 9 mos. 12 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 503 Dolphin Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: JOHN SMITH

3. (b) Social Security Number: -------

4. Sex: male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years: 32 Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/15-9 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville

18. Funeral director: Supt.
Address: Crownsville, Balto.

19. Dec. 15 1939 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10th 1939, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28th 1935, to Dec. 10th 1939, and that I last saw him alive on Dec. 10th 1939.

Immediate cause of death: General paralysis of the insane — DURATION
Due to
Due to
Other conditions: Lues
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ------
Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of
Where did injury occur? -------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: ------ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 12/10/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

11722

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundle

City or town: Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 78 Maryland Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 27 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Annapolis Ward No. 1st

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 78 Maryland Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Isaac Snyder

WITHIN CORPORATE LIMITS OF

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or wife: Minnie Snyder

6(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): April 27, 1880

8. AGE: Years: 59 Months: 6 Days: 14 If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Uniform Tailor

11. Industry or business: Business

FATHER

12. Name: Isaac Snyder

13. Birthplace: Poland

MOTHER

14. Maiden name: Unknown

15. Birthplace: unknown

16. Informant: Jacob Snyder

Address: 78 Maryland Ave Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 12 1939 (month) (day) (year)

Cemetery or crematory: Kneseth Israel Cemetery

Location: Three Mile Oak

18. Funeral director: B.L. Hopping

Address: Annapolis, Maryland.

19. 212 (Date rec'd by registrar) 1939 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 - 11 1939, at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to Dec 11 1939, and that I last saw him alive on Dec 10 1939.

Immediate cause of death: Acute Dilatation of Heart. — DURATION: Sudden

Due to: Hypertension — unknown

Due to: Arteriosclerosis — unknown

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C Basil M. D. or other

Address: Annapolis Md Date signed: 12-11-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T) (I)

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

12493

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Stone Run
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME

Stanley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1939

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Fred Stanley
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Addie Cleveland
15. Birthplace: South Carolina

16. Informant:
Address:

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director:
Address:

19. 12-13-39 (Date rec'd by registrar) 19 39 Z. A. Breit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 19 39, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19,
and that I last saw h alive on 19.

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Sign Z. A. Breit, M.D.
M. D. or other

Address: Pasadena, Md. Date signed:

Stillb.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11723

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town West Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town West Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Randall St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eva Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William E. Thomas
6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) May 11th 1882

8. AGE: Years 57 | Months 6 | Days 20 | If less than one day ____ hrs. ____ min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER
12. Name John Hutchinson
13. Birthplace A. A. Co Md.
MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant William E. Thomas.
Address West Annapolis Md

17. Burial Date thereof Dec 4th 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18. Funeral director John H. Taylor
Address Annapolis Md.

19. 12 3 1939
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1939, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20, 1939, to Dec. 1, 1939 and that I last saw h- alive on Dec. 1 1939

Immediate cause of death	DURATION
1) Acute Dilatation of the Heart	Minutes
Due to 2) Cardiac Hefeitis	1 yr.
Due to 3) Interstitial Nephritis	1 yr.
Other conditions 4) Diabetes Mellitus	5 yr.

(Include pregnancy within 3 months of death)

Major findings:
Of operations Not
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson MD
M. D. or other
Address Annapolis, Md. Date signed 12-4-39

RECEIVED
JAN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46-B)

11724

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 519 Sixth St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ____ County ____
City or town ____ Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Ellen Elizabeth Tyler
3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Clarence E. Tyler
6(c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.): Nov 19th 1887
8. AGE: Years 52 | Months 1 | Days 5 | If less than one day ____ hrs. ____ min.
9. Birthplace: Eastport Md. (Town, county, and state)
10. Usual occupation: house
11. Industry or business
FATHER
12. Name: Henry T. Boettcher
13. Birthplace: Washington D.C.
MOTHER
14. Maiden name: Frances Clark
15. Birthplace: A. A. Co Md
16. Informant: Clarence E. Tyler
Address: 519 Sixth St. Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27th 1939 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. 12 [illegible] 1939 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24th 1939, at 2:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1934, to Dec 24 1939, and that I last saw her alive on Dec 24 1939.
Immediate cause of death: Intestinal Obstruction
Due to: Cancer of Colon. General inanition
Due to: Recent involvement
Other conditions: Cancer of Colon Two separate involvements
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION: several weeks about 2 yrs. 5 yrs.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Oliver Purvis M. D. or other
Address: Annapolis Md Date signed: Dec 25/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 8 1910
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11725

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (107)

County A. A. Co. Registration Dist. No. 216

Village or City Shady Side Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Herbert Leon Tyler If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Col-	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day, end year) Sept 17, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	2	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Not Any

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Shady Side (State or country) A. A. Co., Md.

FATHER

13. NAME Russell Tyler

14. BIRTHPLACE (city or town) Churchton (State or country) A. A. Co. Md

MOTHER

15. MAIDEN NAME Rachel Brewer

16. BIRTHPLACE (city or town) Shady Side (State or country) A. A. Co. Md

17. INFORMANT Katherine Brewer (Address)

18. BURIAL, CREMATION, OR REMOVAL Place St Matthews Church Date Dec 2, 1939

19. UNDERTAKER T. A. Hardesty & Sons (Address) Galesville Md.

20. FILED Dec 2, 1939 J. B. Dent Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 1st (Month) (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1939, to Dec 1st, 1939

I last saw him alive on Nov 26, 1939; death is said to have occurred on the date stated above, at 2:30 A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	Nov 23 1939
Other **Contributory Causes** of importance:	
Chronic Sprue	
Empyema	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Wes disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) F. B. West M. D.

(Address) Galesville Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

11726

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 8days

Stay in this community (yrs., or mos., or days) 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Springs Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ----------
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -------

3. (a) FULL NAME Pearl Wallace

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Black

6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife None

---- 6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 50 | Months Unknown | Days | If less than one day ---- hrs. ---- min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business ------

FATHER
12. Name Louis Wallace
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Lewis
15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-3-40 (month) (day) (year)

Cemetery or crematory Lincoln Cemetery

Location Suitland, Md.

18. Funeral director W. Ernest Jarvis

Address 1432 U St. N. W. Washington, D.C.

19. Dec 29 1939 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1939, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 1939, to December 29 1939, and that I last saw her alive on December 29 1939.

Immediate cause of death Diabetic Coma — DURATION 48hrs.

Due to Diabetes Mellitus — Unknown

Due to ------

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations -------

Of autopsy ------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide --- Date of ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury ---- Injured at work? ----

23. SIGNATURE Robert P. Kirkwood M. D. or other

Address Crownsville, Md. Date signed 12/29/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

11727

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 24 Pleasant St
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 8 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 24 Pleasant
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles Washington

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife: —
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9. 1939

8. AGE:

Years	Months	Days	If less than one day
	8	14	hrs. min.

9. Birthplace: Annapolis, A.A. Co. Md
(town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER
12. Name: William Isaacs
13. Birthplace: Annapolis Md

MOTHER
14. Maiden name: Martha Washington
15. Birthplace: Annapolis. Md

16. Informant: Martha Washington
Address: 24 Pleasant St. Annapolis

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Brewer Hill Dec. 16 1939
Location:

18. Funeral director: E H B Parker
Address: 47 Washington

19. 12-15-1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14 1939, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination 19, to 19, and that I last saw h alive on 19

	DURATION
Immediate cause of death: Acute Myocardial failure	sudden
Due to: Bronchial-Asthma	8 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause fo which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey Deputy medical examiner
M. D. or other
Address: Annapolis Md Date signed 12/14/39

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BUREAU V. S.

11728

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Manhattan Beach
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Dividing Road

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Manhattan Beach Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Dividing Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Charles C. Waskey

3. (b) Social Security Number:

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charlotte Waskey

6 (c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Sept. 6. 1858

8. AGE: Years: 81 Months: 3 Days: 22 If less than one day: hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Furniture business

11. Industry or business: Proprietor

FATHER
12. Name: Benj. Waskey
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Sarah Hollis
15. Birthplace: England

16. Informant: Mrs. Eva Hungerford
Address: Manhattan Beach Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec. 29, 1939 (month) (day) (year)

Cemetery or crematory: Louden Park

Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. December 29 1939 (Date rec'd by registrar) M R Dealba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1939, at 12 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Post Mortem Exam.

Immediate cause of death: Acute myocardial disease — DURATION: sudden

Due to: Chronic nephritis — 1 year or more

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis. Md Date signed: 12/28/30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

11729

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 109 McKendree Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

WITHIN CORPORATE LIMITS

3. (a) FULL NAME Earle C. White Sr.

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Ester P. White

Dead 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14th 1885

8. AGE: Years 54 Months Days 2 If less than one day hrs. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation Clerk Midshipmans Store

11. Industry or business U.S. Naval Academy

FATHER
12. Name Francis O. White
13. Birthplace Maryland

MOTHER
14. Maiden name Martha E. Dye
15. Birthplace Kt.

16. Informant Earle C. White Jr.

Address Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19th 1939 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 1219 (Date rec'd by registrar) 1939 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1939, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1939, to Dec 16 1939, and that I last saw him alive on Dec. 16 1939.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions Marked secondary anaemia
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 1 yr (?)

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D. M. D. or other

Address Annapolis Md Date signed 12/19/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11730

Reg. Diat. No. 21

1. PLACE OF DEATH:

County aa

City or town Arnold

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County aa

City or town Arnold Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Premature Infant Ward

3. (b) Social Security Number

4. Sex: F

5. Color or race: Col

6. (a) Single, married, widowed, or divorced

B (b) Name of husband or wife Horace Maynard

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31 39

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace aa Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Horace Maynard

FATHER 13. Birthplace aa Co Md

MOTHER 14. Maiden name Rachel Ward

MOTHER 15. Birthplace Anne Arundel Co Md

16. Informant Lydia Poole

Address Arnold

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1 1 1940 (month) (day) (year)

Cemetery or crematory Arnold

Location Albert Howard

18. Funeral director Albert Howard

Address Arnolds

19. 39 Dec 31 19 39 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 39, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death	Premature birth	
Due to		
Due to	no Medical Attendance	
Other conditions		

DURATION

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Murphy Registrar M. D. or other

Address Annapolis Date signed 12-31-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

11731

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Jewell
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still Birth — Young

3. (b) Social Security Number

4. Sex F

5. Color or race Colored

6.(a) Single, married, widowed, or divorced

6 (b) Name of husband or wife none

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/39 Still Born

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William Young
13. Birthplace Maryland

MOTHER
14. Maiden name Louise Spriggs
15. Birthplace Maryland

16. Informant William Young
Address Jewell. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/28/39 (month) (day) (year)
Cemetery or crematory Friendship
Location " Md

18. Funeral director Williams Young.
Address Jewell Md

19. 12/28 1939 (Date rec'd by registrar) W.R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1939, at 4.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attendod deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death	DURATION
Premature Birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emily H Wilson M.D.
M. D. or other
Address Lothian. Md Date signed 12/27/39

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JAN 8 1940
BUREAU V. S.